Vermont EMS Today

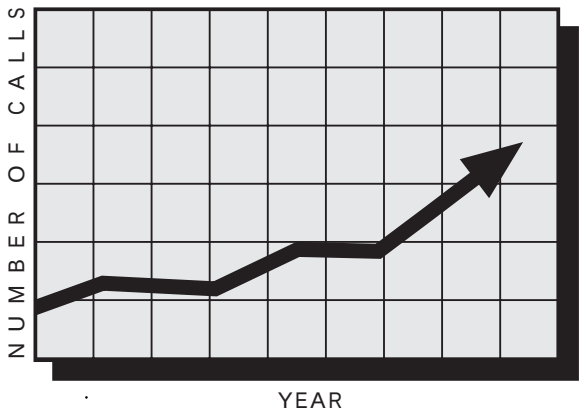
May 2002

From the Director

Turn Up The Volume…

I've been in EMS for over 27 years now and the great news is that I still love responding to emergency calls. Every time the tones go off, it's an opportunity to help someone. Each emergency situation is another challenge that puts the training, experience, teamwork and preparations we all share to the test.

Over the years, I have worked with many different kinds of EMS responder organizations. Some have had relatively large call volumes while others have had much smaller volumes. There is strong evidence to suggest that organizations with large or growing call volumes tend to be more durable and successful than those with smaller call volumes. There are several reasons that may account for this phenomenon.



EMS personnel affiliated with organizations that have higher call volumes generally have higher numbers of patient contacts. Nothing improves performance like practice. I suspect that most of us are very comfortable using oxygen delivery systems to assist a patient having difficulty breathing. It is one of the most common tasks performed by EMS providers. Similarly, I suspect that few of us are as comfortable managing a complicated in-field obstetrical delivery which is a much less common presentation. Irrespective of the type of call, organizations with larger call volumes tend to have more opportunities for their personnel to see the range of patient presentations and to gain experience in the management of those patients.

Nothing improves performance like practice.

To a great extent, EMS organizations are inherently inefficient economically. Virtually every EMS organization in Vermont (and most nationally) spends a majority of the time prepared to respond, but not actually performing a response. This is natural given the obvious unscheduled nature of emergencies.

From an economic perspective, an EMS organization is like an expensive machine that produces EMS responses. When the machine is busy, the resource is being used efficiently to make product. When the machine is idle, there is no product being made. Just building the EMS machine and having it available to respond is expensive in terms of capital costs and the human resource costs. If General Motors had to maintain an assembly line operation to build only a few hundred cars each year, the cost per car would be prohibitive. By building large numbers of cars from each assembly line, the cost per car is much more affordable.

More evidence for this economic theory was provided by a piece of research that Project Hope did for the American Ambulance Association. Project Hope's work showed that the cost per call for ambulance service generally declined until a call volume of about

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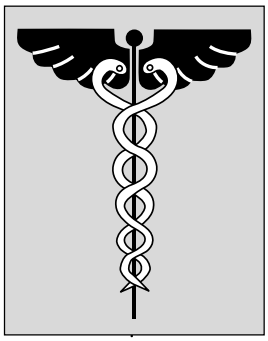
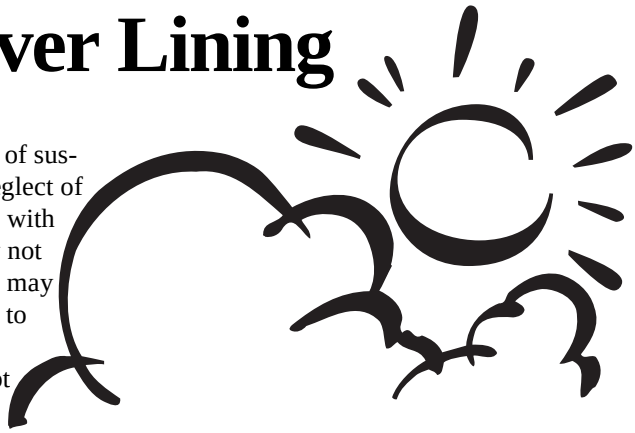
Inside

From the Medical Advisor

Sometimes There Is A Silver Lining





As health care providers, we have an obligation to report suspected or known child abuse and we know it. No doubt, we all wish that it were always an easy thing to spot; often, it is not.

I recently treated a young child for a leg fracture, specifically a spiral fracture, that should make one think of abuse. Several physician colleagues in disciplines other than emergency medicine were not thinking of abuse and even after seeing the child, had a low level of concern and interest. Shortly after the police and SRS arrived to talk to the caregiver, there was a confession of the crime and that person is now getting the needed help to become the sort of parent we all strive to be. There can be a silver lining to black clouds.

The reporting of suspected abuse or neglect of children is fraught with difficulty. We may not think of abuse and may have little training to recognize it. Our colleagues may not agree with our concern or assessment. Worst of all, if we are in error, there are tremendous resources which seemingly have been wasted and the stain on the family may linger forever.

My recent case reminded me that we need to train to know when there is reasonable cause to believe that abuse or neglect of a child is occurring. We need to realize that, even when no one else shares our concern, we are compelled to act. We need to recognize that the resources are graded and measured and no one will fault us for reporting when there is reasonable cause to believe that a child has been abused or neglected. The professionals who investigate are very much aware of and work diligently to avoid the perception of stain for the family. Finally, we must recognize that failure to report is against the law and might well compromise the health and well-being of a human life; there can well be a very positive outcome with needed help being offered to deserving caregivers.

We may not think of abuse and may have little training to recognize it.

It is sad but true that child abuse and neglect take place in our communities. We have a responsibility and obligation to these victims. Performing a medical intervention in the field is easily recognized as a lifesaving intervention. Reporting abuse and neglect of children can also be lifesaving. I hope that you will consider reviewing your training materials in this important area, or call your local SRS office to request training so that you can do your part. A life may well depend upon your lifesaving skill.

—Wayne J.A. Misselbeck, M.D.
State EMS Medical Advisor

Vermont EMS Today
is published as a service for Vermont's emergency medical providers. Suggestions, comments and news items are always welcome. Write or call Leo J. Grenon, Vermont Dept. of Health, 108 Cherry Street, Box 70, Burlington, VT 05402. (802) 863-7310 or 1-800-244-0911 (in Vermont only). Email: VTEMS@VDH.STATE.VT.US

Division of Health Protection
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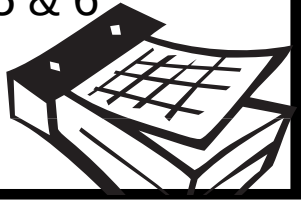
EMS Week
May 19—May 25, 2002

MARK YOUR CALENDAR!
2003 EMS Conference
April 5 & 6



From the Director—

Turn Up The Volume…

CONTINUED FROM PAGE 1

5000 annual responses at which point the cost leveled out and then increased slightly at much higher call volumes.

Beyond just personnel experience and money, there are other issues that may make low volume responses more challenging. Vermont's lowest volume services tend to be in some of our most isolated and difficult to serve locations. While the call volumes of our smallest EMS organizations are a fraction of our larger squads, the patients encountered require just as much care. Often they require care for longer periods of time (i.e., due to transport distances to hospitals). The resources of some small EMS organizations may be strained in terms of their ability to access mutual aid, to maintain the internal capacity to handle multiple simultaneous calls, or even to handle more than one patient at the same incident.

While the observations I make may seem obvious, it is less apparent what an EMS organization can or should do to maintain or expand its call volume. Consider the following questions:

1. **Do we know what our call volume trends are?**
   Many Vermont EMS organizations report growing call volumes in most years. This may be due to increasing populations, the aging of the population in general, better public awareness of EMS, statewide 9-1-1, or a variety of other factors. EMS organizations need to look both at history and trends for the future to plan for the resources they will need to meet anticipated call demands.

2. **What kind of exposure to patients is each of your members or employees getting?**
   Within every organization there are people who are very active and others who are less so. Is your organization able to track the number and type of patient contacts that each of your members has annually? Has your organization become heavily dependent on the contributions of just a few people? Are there people in your organization who rarely have contact with patients? Is there anything you can do at the organizational level to assure that all of your members or employees get regular contact with patients?

3. **As an ambulance service, are we actually serving the complete needs of our service area?**
   Some squads choose not to do non-emergency trips based on the need to preserve their response resources for emergencies. While emergencies are the obvious priority for all EMS organizations, don't ignore the possibility that taking non-emergency calls might benefit the organization as a whole. Non-emergency trips may bring additional revenue to the service. They give personnel one more encounter with a patient who will at a minimum be assessed, transported and documented in a low stress environment. Handling non-emergency trips may also solidify the mission of the organization within the community.

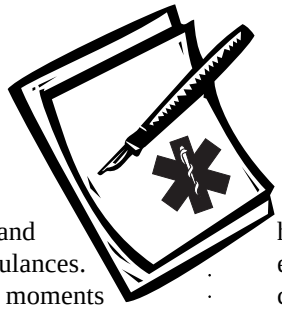
4. **As a first responder service, are we meeting the complete needs of our service area?**
   Does your organization respond only to emergency calls? What about stand-by coverage for significant community events such as large gatherings, athletic competitions, etc? Are you responding in conjunction with fire calls for stand-by during active operations?

As a statewide EMS system, we may need to consider whether the number of services we license is the right number to optimally serve the needs of Vermonters. In recent years, the number of First Response agencies has increased. This trend may be a good thing in that local First Responders may be able to provide a faster response than what had been available in the past. On the other hand, a growing number of organizations may be competing for the same limited workforce of EMS providers and new recruits. A growing number of EMS organizations may also dilute the contact with patients that any individual EMS provider is able to have. A few EMS organizations have explored or are exploring the possibility of combining operations to build a larger more sustainable delivery model.

Throughout my EMS provider career, I've always maintained that I never wanted anyone to get sick or injured and require an emergency response. By the same token, I am never disappointed when the patients who inevitably need an EMS response enter the system on my shift.

—Dan Manz
State of Vermont
Director, EMS

Operations Update



First of all, I'd like to thank those of you who commented on my article entitled "Grey-Area Response" which appeared in the last issue of *Vermont EMS Today.* I was pleased to see that the article was both a formal and informal topic of discussion among EMS providers and administrators. If any of you would like more information or references for further research, please contact me. Below are some items of interest related to EMS operations:

- The second tour of ambulance inspections is underway. This tour will concentrate on ambulance services in District 1 through District 6. The inspection procedure is very similar to the process from past years, and also allows me to visit with you and your squad about daily operations. I will be contacting squad chiefs by phone or email prior to the anticipated date of inspection. The Vermont EMS Rules booklet and the EMS Office website (http://www.state.vt.us/health/ems) contain information on equipment requirements for ambulance services licensed in Vermont. Please contact me if you have questions about these requirements or if you'd like any clarifications.

- A reminder: all Vermont-licensed ambulances registered by the Vermont Department of Motor Vehicles (DMV) require red light permits, issued by DMV. Please keep the yellow copy of your red light permit (once processed by DMV) along with your DMV Registration Certificate in the ambulance vehicles and available for inspection. If you have questions about red light permits (or do not have a red light permit issued for your ambulance) please contact DMV at 802-828-2000 or visit their website at http://www.dmv.state.vt.us.

- The EMS Office has Temporary Ambulance Registration forms available for loaner and newly acquired ambulances. The form takes only moments to complete and can be mailed or faxed to the EMS Office on or before the in-service date of the ambulance. The form, once approved and sent back to the service, should be placed in the ambulance vehicle with the DMV Registration Certificate. This form acts as a temporary ambulance inspection until actual inspection by a Vermont EMS Office representative occurs. These forms are available upon request from the EMS Office.

- The EMS Office is responsible for investigating any individual with a past criminal conviction who is applying for Vermont EMS certification. Because it is so important to be thorough, investigating these cases is often time-consuming. Depending on the nature and date of the conviction and whether it occurred in Vermont or in another state, some cases take longer to resolve than others. Factors that may result in more lengthy investigations include Vermont convictions prior to 1995 and out-of-state convictions. Vermont court records prior to 1995 are often stored on microfilm outside of the county courts. For this reason, it takes some time for our office to obtain copies. Out-of-state conviction records may also take time to obtain depending on the release procedures of the individual states. If applicants or service chiefs have any questions regarding the status of an open investigation, please contact me.

- I have received some information and research studies pertaining to the difficulty of checking tire pressures of ambulances with dual-wheel configurations, the use of clamp-in tubeless metal tire valves, and use of double-seal valve caps. These studies emphasize the importance of regular tire pressure checks and suggest ways to reduce excess air leakage. I am happy to discuss these issues and, if enough interest is generated, possibly compose an article on these topics in our next newsletter.

- Vermonters can now call 1-800-222-1222 to reach a poison expert 24 hours a day, seven days a week. Vermont merged with Maine in 2001 to create the Northern New England Poison Center, operated through an agreement with the State of Maine and located at the Maine Medical Center in Portland. Callers will be immediately connected to specially trained nurses, pharmacists, and doctors, and the toll-free number works anywhere in the country.

- The New England Council for Emergency Medical Services (NECEMS) is revising its disaster plan, which is presently being used by most EMS agencies licensed in Vermont. Services will be contacted with further information about plan changes upon approval of the revisions by the Council.

I can be reached here in the Vermont EMS Office by phone at 1-800-244-0911 (within VT) or 802-863-7310, or via email at ssaleng@vdh.state.vt.us. Please feel free to contact me if I can be of assistance to you or your service with the above-mentioned topics or any other matters relevant to the day-to-day functioning of your squad.

—Steve Salengo
EMS Operations Coordinator

Number of people holding Vermont EMS certification as of 12/31/01:

ECA		796
EMT–Basic	(does not include advanced levels)	1224
EMT–I		830
EMT–P		97
Total EMTs at all levels:		**2,151**

Training UPDATE

Year in Review

The state's fiscal year ended June 30, providing time to gather statistics about what happened in training and education during fiscal year 2001.

CONTINUING EDUCATION

Once again, more than 700 people attended the Vermont EMS conference in the spring. The 13th annual conference saw the return of several popular speakers from past conferences, as well as some new faces. The popularity of pre-conference workshops continued to grow, with some sessions unable to accept all of the people who wished to attend. EMS Office staff also provided initial and continuing education by opening a number of EMT-Basic and EMT-Intermediate courses and making other presentations to EMS providers.

COURSES

Forty first responder courses under the new curriculum took place this year. The number of EMT-Basic, EMT-Intermediate and EMT-B refresher courses remained fairly stable compared to last year. (See below.)

INSTRUCTOR DEVELOPMENT

Sixteen more EMTs completed the EMS Instructor course in March 2001. They all received orientation to Vermont's rules and policies at the end of the course. In all, 87 EMTs from Vermont have completed the course since it was first conducted more than 10 years ago. Most graduates are coordinating courses, but a significant number have never coordinated a course.

EMT-INTERMEDIATE CURRICULUM

EMS continued the process begun the year before of adapting the new national standard EMT-Intermediate curriculum for use in Vermont. After district medical advisors came to consensus on the scope of practice of the EMT-I of the future, district and other officials had an opportunity to consider the feasibility of such a course in Vermont.

The new curriculum, as adapted for Vermont, will include a number of new interventions. Although it is not clear how long the course will be, the present 63 classroom hours and 20 clinical hours will not provide sufficient time or exposure for students to develop competence.

The interventions that will be in the new course include current treatments such as peripheral intravenous therapy, phlebotomy, 50 percent dextrose, 1:1000 epinephrine and naloxone. New interventions will include:

- pulse oximetry
- blood glucose measurement
- Esophageal Tracheal Combitube®
- aspirin
- nitroglycerin
- nebulized beta agonist bronchodilator
- glucagon
- thiamine
- use of the Broselow tape.

The EMS Office is now editing the curriculum outline to match the new scope of practice. EMT-I course coordinators will then receive orientation to the material and begin teaching EMT-I transition courses. An EMT-I who has completed a transition course will then be able to assist in the teaching of practical skills to students in initial courses.

	1993	1994	1995	1996	1997	1998	1999	2000	2001
EMT-BASIC	14	16	17	10	16	17	21	25	19
EMT-INTERMEDIATE	11	12	11	14	7	10	11	8	10
EMT-B REFRESHER	NA	NA	NA	NA	NA	NA	2	11	13
TOTALS	25	28	28	24	23	27	32	33	29

(without refresher courses)

CERTIFICATION EXAMINATIONS

More than 900 EMTs who were due to take the test for recertification received a reminder and an exam registration form in the mail. About 700 EMTs renewed their certifications. With the cooperation of district officials, course instructors and EMTs, the number of times EMS office staff traveled to conduct EMT certification exams remained manageable.

YEAR	EXAM TRIPS
1992	60
1993	28
1994	24
1995	29
1996	29
1997	33
1998	31
1999	42
2000	35
2001	44

ESOPHAGEAL TRACHEAL COMBITUBE

Between July 1, 2000 and June 30, 2001, 219 EMT-Intermediates completed 21 Combitube courses, raising the number of providers trained in the use of this device from 34 to 253. The Combitube became the airway of choice for EMT-Is in EMS Districts 2 (the Newport area), 4 (Morrisville), 5 (St Johnsbury), 6 (Barre-Montpelier), 7 (Middlebury-Bristol), 8 (Randolph), 11 (Springfield) and 13 (Brattleboro).

AGENDA FOR THE FUTURE

The National Association of EMS Physicians completed their contract with the National Highway Traffic Safety Administration to draft the EMS Education Agenda for the Future, a document designed to guide and assist in the progress of EMS research. A rollout of the document is expected in 2002.

—Mike O'Keefe
Training Coordinator

Making Exceptional the Rule: One Year Later

A year ago, I wrote an article in this newsletter called "Making Exceptional the Rule" [*EMS Today,* March 2001]. It discussed the results of a survey that we sent out in late 2000 to help us determine how well we were serving the ambulance and first response agencies we license. According to the survey results, only 78 percent of the services that contacted us in the last half of 2000 felt their experience was "appropriate and professional." That meant nearly one out of every four services were less than satisfied with their interactions with the EMS Office.

As I mentioned in that article, I was disappointed that the survey did not give respondents an opportunity to say if we were actually better than "appropriate and professional." When we sent out license renewal forms in late 2001, we asked different questions and got some encouraging results. Of the 85 agencies that responded, 25 squads deemed their contact with the EMS Office to be very positive, 37 said it was generally positive and 16 felt it was adequate. One squad reported that our performance was less than adequate and one reported receiving poor service. Five squads told us they had not tried to contact us in the previous six months.

As these numbers reveal, more than 97 percent of the services that had contact with the EMS Office in the last half of 2001 received adequate or better service and 77.5 percent rated their service generally positive or better. Nearly one in three said their contacts were very positive.

I am pleased that all but two squads that responded to our survey were satisfied with the service they received. It shows that our efforts to improve over the past year have begun to pay off. EMS providers are now receiving exam results in less than a week. Service license renewal forms were sent earlier than usual this year. Our new operations coordinator, Steve Salengo, has developed efficient and thorough procedures for investigating EMS providers whose certifications might be in jeopardy. He also implemented a plan to ensure more regular ambulance inspections. The centralization of the routine administrative tasks has allowed Dan Manz, Mike O'Keefe and others on staff to focus on policies, programs and resources that are enhancing EMS systems in Vermont.

Still, there are some areas that leave room for improvement. Because of an antiquated, labor-intensive computer system, it still takes too long to process a certification after an exam. While we explore various options for replacing this system, we are also looking for ways to tweak the existing system to speed up the turnaround on certification cards.

The Vermont EMS Office is committed to being a reliable source of information and support, particularly in light of the increased expectations placed on emergency services in recent months.

September 11 had a profound effect on our operations, as it did for almost everyone. Suddenly, our staff had another very important mission that continues today: a) ensure that our current functions can continue in the event of another tragedy and b) keep abreast of the evolving issues relating to terrorism so that we can be an up-to-date, definitive resource to the EMS community. Meeting these new requirements has tested us and I believe made us a stronger, more efficient organization.

Two of the most visible effects of that shift in focus have been the delayed publication of our December newsletter and the EMS Conference brochure. Both were on track to be distributed in late December, but the events of September 11th dramatically affected both the content and timetable for these projects. Hopefully, another tragedy of that proportion will never happen again, but if it does, we are better able today to stay on track with routine operations while fulfilling our role in crisis management.

Those outside the EMS Office can measure our performance in terms of the quality and timeliness of our services. Internally, we have instituted systems to track our performance, and we analyze these results regularly.

The Vermont EMS Office is committed to being a reliable source of information and support, particularly in light of the increased expectations placed on emergency services in recent months. We are very interested in hearing your ideas on how we can serve you better. Don't hesitate to get in touch with us if you have questions, comments or suggestions.

The level of service provided by the Vermont EMS Office may not yet be "exceptional," but this year's survey indicates we are heading in the right direction. I look forward to working with you in the future as we move closer to our goal of *Making Exceptional the Rule.*

—Ray Walker
Programs Administrator

Toll-Free Number

Save yourself some money.

When calling EMS from within Vermont, use our toll free number:

1-800-244-0911

EMS Fax Number **1-802-863-7577**

Email **VTEMS@VDH.STATE.VT.US**

Vermont EMS Data Project Update

This winter, the Vermont EMS Data Collection Task Force attended a presentation on the Delaware EMS data system. The Delaware system, which is called the EMS Data Information Network (EDIN), has many of the components we would like to see in a Vermont EMS data system. The members of our task force had a favorable impression of the features EDIN offers its users. Since this system might ultimately be used in Vermont, I'd like to explain how it works.

After each call, EMS providers complete a computerized patient care report (PCR). This report can be entered on any computer with Internet access. Typically, the report is completed at the receiving hospital. For some calls, the PCR is very short. For example, when a patient refuses treatment and transport, only a short list of data is needed. On the other hand, if a paramedic runs a cardiac arrest with numerous medications and procedures, the PCR is much longer. A computerized report typically takes more time to complete than a paper form. However, the slight increase in time is easily justified when you consider the utility of computerized data vs. a handwritten form.

In some cases, an EMS unit might get called out for another emergency before the computerized PCR can be completed. Fortunately, the EDIN system has a rapid log out feature. This means that EMS providers can quickly log out of the system and respond to another call. The information already entered on the computerized PCR will be waiting for the EMS provider upon return.

Vermont EMS providers have a wide variety of computer experience. Whether you are a computer programmer or a beginning computer user, the EDIN system will be easy to learn. The graphical menus are easy to understand and use. The entire system is intuitive and user friendly. Delaware EMS has found that only a brief training session is necessary before EMS providers feel comfortable with EDIN.

Data security was a top concern in developing EDIN. EMS data are kept on a secure server with regular back-ups. Various security levels ensure that only authorized personnel can view any data. For example, an EMS provider will be able to view all his or her reports, but not those of another provider. EMS administrators will be able to view data from their own service, but not that of another service. District medical advisors will be able to view data from their own district. On a larger scale, some data will be stripped of patient identifiers and made available to the general public. For example, we may release statistical data on the number of car crashes in our state.

The majority of the data in the PCR are standard, however EDIN allows each service to custom define several data elements. If your EMS organization has a special project or special data needs, EDIN will be able to accommodate you. Your service might decide to track calls on the east side of town versus the west side of town. You may want to track special data for a research project or for a special grant. These fields can be modified by your service whenever the need arises.

Another great feature of EDIN is internal email. Users within the EDIN system can send messages to each other. These messages are like traditional email systems, but they only work internally. In other words, you won't be able to send a message to your friend in Detroit, but you will be able to reach every EMS provider in Vermont. This communications system will allow us to quickly advise Vermont EMS providers about important EMS issues. Notification of unread messages will appear each time a provider logs into EDIN.

As mentioned earlier, Vermont will probably adopt either the EDIN system itself or a system similar to EDIN. Several other states are also looking at EDIN as an answer to their data needs. If several states use EDIN, it will be the first time that a multi-state data system has been created.

If you are interested in seeing a live demonstration of EDIN, please call or visit me at the EMS Office. I would be happy to show you this system and how it works.

—William Clark
EMS-C Coordinator

2002 EMS Award Winners!

First Responder of the Year
Jill Mattison

EMT-Basic
of the Year
Maryann Jakubowski

EMT-Intermediate of the Year
Mark Podgwaite

EMT-Paramedic of the Year
Michael Wright

EMS Educator of the Year
Mark Onyon

EMS Leader of the Year
Brian Fox

Emergency Nurse of the Year
Christian Phelps, R.N.

Emergency Physician of the Year
John Minadeo, M.D.

First Responder Service of the Year
Stowe Evacuation Team

Ambulance Service of the Year
Barton Ambulance Squad

Vermont SAFE Kids Injury
Prevention Award
Colleen Gilman

Vermont Ambulance Association
Chuck Hoag Memorial Scholarship
Kandis Decker-Holden

Community Service Tip

Think of your neighbors as the drought continues… some are still without water. Take time to give them a call or check on them.

Governor Dean Leads "Click It or Ticket" Campaign

How much is the click of a seat belt worth? Severe injury? A life? A traffic ticket?

In May, Vermonters will learn about the importance of buckling their seat belt through an intensive media campaign coupled with a high visibility enforcement period. The effort, part of a national program called "Click It or Ticket," is based on years of research proving that for many who don't buckle up—especially young drivers—the possibility of receiving a ticket is a more powerful incentive than the threat of injury or death.

Click It or Ticket is aimed at reducing injuries or death caused by traffic crashes, which are a leading cause of death. Failure to buckle up contributes to more fatalities than any other single factor. Unbuckled crash victims die more frequently and the treatment costs for those who survive is 60 to 80 percent higher than if they had been properly buckled up.

Vermonters could do better. Our seat belt buckle up rate is just 67 percent. We rank a poor 40th nationally in usage. North Carolina, on the other hand, has an 83 percent compliance rate after using the "Click It or Ticket" approach. If Vermont increases seat belt use by just 10 percent, lives will be saved and Vermont health care dollars will not be used unnecessarily.

A team headed by the Governor's Highway Safety Program is working to ensure that Vermonters will learn about the "Click It or Ticket" program. On May 8th, Governor Howard Dean will announce his active support for the campaign. He will be joined by others in the medical, health and law enforcement communities to emphasize the importance of buckling up.

From May 13 to Memorial Day, Vermonters will see a strong media campaign publicizing "Click It or Ticket." The ads target those who traditionally don't buckle up, but the goal is also to reach the occasional seat belt user who wears a belt on the highway but not on short trips.

"Click It or Ticket" goes beyond the media campaign. From May 20 through the Memorial Day weekend Vermont's law enforcement agencies will be out in full force in each county patrolling and operating safety checkpoints. While education is important, law enforcement knows that it takes a combination of approaches to make this campaign effective. While officers don't want to write tickets, they will tell you that the choice between writing a ticket and knocking on a door to inform family of the death of a loved one is a very simple choice. If writing a ticket will save your life, the officer will write the ticket.

For more information on "Click It or Ticket" contact the Governor's Highway Safety Program at 1-802-241-5509.

Vermont Highway Accident Statistics:
From 1997 through 2001, Vermont crash studies show that 456 people died on Vermont roadways, and 35,597 were injured. An economic study based on nationwide research from the National Highway Traffic Safety Administration determined the total cost of all motor vehicle crashes during the past five years was a staggering $1.2 billion. One fatality costs the economy an average of more than $825,000. The average expense of a minor injury crash is nearly $7,400, which means Vermonters spent $54 million for the least serious crashes over the past half-decade.

—Submitted by
Jeanne Johnson,
Director of the Governor's
Highway Safety Program

Vermont Emergency Medical Services

108 Cherry Street
P.O. Box 70
Burlington, VT
05402

802-863-7310
1-800-244-0911
(within Vermont)